IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM AND WAIVER PERSONAL CARE SERVICES (WPCS) PROGRAM LIVE-IN SELF-CERTIFICATION CANCELLATION FORM FOR FEDERAL AND STATE TAX WAGE EXCLUSION

Provider Name	Recipient Name
Provider Number	Recipient Case Number
County Of Residence	

ALL INFORMATION ON FORM MUST BE PRESENT AND COMPLETED IN ENGLISH TO CANCEL EXCLUSION.

SEE PAGE 2 FOR INSTRUCTIONS.

I no longer live with my Recipient _____, and would like to remove the existing Self-Certification for the exclusion of my IHSS/WPCS wages from federal and state personal income taxes.

Provider Signature:	Date of Signature:

RETURN COMPLETED FORM TO:

IHSS – IRS Live-In Self-Certification
P.O. Box 1677
West Sacramento, CA 95691-6677

Instructions for filling out the Live-In Self-Certification Cancellation Form

1. All requested information must be entered in English on the form in the designated area.

2. You must sign and date the form on the designated line.

3. Only use black ink and please print clearly.

4. Do not wrinkle or staple the form.

5. Provider Name: Enter your name as it appears on your IHSS paperwork.

6. Provider Number: May be found on your IHSS paperwork – Provider Notification of Recipient Authorized Hours and Services and Maximum Weekly Hours, Provider Timesheet, etc.

7. Recipient Case Number: May be found on your IHSS paperwork – Provider Notification of Recipient Authorized Hours and Services and Maximum Weekly Hours, Provider Timesheet, etc.

8. Recipient County of Residence: Please enter the county where you and your Recipient reside.